COMMONWEALTH OF VIRGINIA

Virginia Department of Health Professions

Prescription Monitoring Program

Perimeter Center

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233
Phone: (804) 367-1030 or 367-4514
Fax: (804) 527-4470
Email: pmp@dhp.virginia.gov
Web site: www.dhp.virginia.gov

RECIPIENT REQUEST FOR DISCRETIONARY DISCLOSURE OF INFORMATION FROM THE PRESCRIPTION MONITORING PROGRAM

Please provide the information requested below. (Print or Type) Use full name not initials

Full Name:	**Street Address:**	
Mailing Address (if different from street address):	**City:**	**State:**
Zip Code:	**Area Code and Telephone Number:**	
Specific time period to be covered in report (data is limited to two years only):	**Date of Birth:**	**Signature of person making request:**

Request must be accompanied by a copy of a valid photo identification issued by a government agency of any jurisdiction in the United States verifying that the recipient is over the age of 18.

***Request form must include a notarized signature*.**

Subscribed and sworn to me, a notary public in and for the Commonwealth of Virginia at large, on this _____day of _____, _____. My commission expires on the _____day of _____, _____.

_____

Notary Public

Mailing Address of Entity or Individual if Report is to be Mailed to Address Other than Recipient's address :

Name of Entity:	**Attention:**	
Address:		
City:	**State:**	**Zip Code:**

For Department Use Only

Date Received:	**Date of action:**	☐ **Approved** ☐ **Rejected**	**Director or Designee Signature:**

Revised 7/24/2017